unit and short stay cases and transfers except those transfer cases specifically assigned to DRG's that are identified as transfer DRG's. For purposes of establishing initial 1988 rates of payment, however, 1986 data shall be used and reconciled to 1987 data when it becomes available.

(3) Hospital specific case mix index (CMI). The hospital specific case mix index shall be calculated by dividing the weighted cases by the total non-Medicare cases. Weighted cases shall be calculated by multiplying each non-Medicare case as determined pursuant to paragraph (2) of this subdivision by the SIW assigned to that case's DRG and aggregating the results for the hospital. In no case shall discharges associated with short stay patients, exempt unit patients or transfer patients, except those assigned to DRG's that are specifically identified as transfer DRG's, be included in this calculation.

(b) **Group average DRG case-based rates of payment.** The group average reimbursable inpatient operating cost per discharge shall be determined for each hospital in the group based on the wage, power and case mix adjusted group average operating cost per discharge as determined pursuant to this subdivision multiplied by the wage equalization factor (WEF) determined pursuant to subdivision (j) of this section, the power equalization factor (PEF) determined in subdivision (j) of this section and [one plus the hospital-specific indirect teaching adjustment percentage which is

$$[1.89(((1 + r)^{.405}) - 1)]$$

where r equals the facility's ratio of residents and fellows per bed as determined pursuant to subdivision (h) of this section] <u>the indirect teaching adjustment percentage determined pursuant to paragraph (2) of subdivision (h) of this section</u>. To this amount shall be added hospital-specific operating costs per discharge determined pursuant to subdivision (g) of this section divided by the average CMI of the hospital determined pursuant

to paragraph (a)(3) of this section. The group average wage and case mix adjusted operating cost per discharge shall be based on hospital-specific reimbursable operating costs which shall be calculated as follows:

(1) The following costs shall be subtracted from the sum of the hospital's allowable 1987 reimbursable operating costs trended to the rate year pursuant to section 86-1.58 of this Subpart and any adjustments made pursuant to section 86-1.52 (a)(1)(iii)(a) [~~and~~], (iv), **and (v)(a)**.

(i) Medicare costs as defined in subdivision (c) of this section including any costs of a Medicare patient's stay paid for by or on behalf of a secondary payor;

(ii) ALC costs as defined in subdivision (d) of this section;

(iii) exempt unit costs as defined in subdivision (e) of this section;

(iv) direct GME costs as defined in subdivision (g) of this section; and

(v) hospital specific operating costs as defined in subdivision (g) of this section.

(2) The hospital-specific portion of the [~~group~~] **$40 million** base enhancement specified in section 86-1.52(a)(1)(iii)(b) of this Subpart shall be added to the costs determined for each hospital in paragraph (1) of this subdivision, based upon that hospital's pro rate share of the sum of such costs for all eligible hospitals.

(3) The following costs shall then be subtracted from the hospital-specific operating costs determined pursuant to paragraph (2) of this subdivision:

(i) **transfer** costs as defined in subdivision (f) of this section, **including** a proportional amount of hospital

specific costs calculated pursuant to subdivision (g) of this section;

(ii) indirect GME costs as defined in paragraph (1) of subdivision (h) of this section; and

(iii) outlier costs as defined in subdivision (f) of this section, including a proportional amount of hospital-specific costs calculated pursuant to subdivision (g) of this section.

(4) The hospital-specific non-Medicare operating cost determined pursuant to paragraph (3) of this subdivision shall be divided by the hospital's non-Medicare discharges as determined pursuant to paragraph (a)(2) of this section.

(5) The wage, power and case mix adjusted hospital-specific non-Medicare operating cost per discharge shall be determined by dividing the hospital-specific non-Medicare cost per discharge determined pursuant to paragraph (4) of this subdivision by the facility's WEF and PEF determined pursuant to subdivision (j) of this section and the case mix index determined pursuant to paragraph (a)(3) of this section.

(6) The wage, power and case mix adjusted group average operating cost per discharge for the hospital's group shall be the result of total group costs divided by the total group weighted discharges where total group costs shall be the wage and power weighted adjusted hospital-specific non-Medicare operating cost per discharge determined in paragraph (5) of this subdivision multiplied by the non-Medicare discharges for such hospital determined in paragraph (a)(2) of this section for all hospitals in the group summed and where total group weighted discharges shall be the non-Medicare discharges for such hospital determined in paragraph (a)(2) of this section multiplied by the case mix determined pursuant

to paragraph [subdivision] (a)(3) of this section for all hospitals in the group summed.

(i) Hospitals with rates based on budgeted costs and hospitals without historical cost experience shall be excluded from the calculation of the wage and case mix adjusted group average operating cost per discharge.

(ii) The 1987 reimbursable costs and non-Medicare discharges of hospitals excluded from the case payment system because they are participating in a demonstration hospital reimbursement system shall be included in the computations set forth in paragraphs (1)-(6) of this subdivision.

(c) Medicare costs shall mean the result of multiplying the facility's 1985 average routine cost per day times 1985 Medicare days actually paid plus any days for such beneficiaries not paid on the basis of a decision by a review agent that the days were unnecessary plus Medicare's share of ancillary costs as determined pursuant to paragraph (1) of this subdivision plus any secondary payor payments made on behalf of Medicare beneficiaries.

(1) Ancillary costs related to inpatient services provided to beneficiaries of Title XVIII of the Federal Social Security Act (Medicare) including the costs of services reimbursed by secondary payors made on behalf of Medicare beneficiaries shall be excluded on the basis of the ratio of 1985 costs to charges applied to such beneficiaries' inpatient charges. Data from the hospital's Institutional Cost Report shall be used and shall be reconciled to paid claims data for Medicare patients including the paid claims reimbursed by secondary payors made on behalf of Medicare beneficiaries from the hospital's Provider Statistical and Reimbursement Report for 1985.

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(d) ALC costs shall be the result of multiplying the 1987 group average operating rate for hospital-based residential health care facilities established pursuant to Subpart 86-2 of this Title by the facility's 1986 ALC days reconciled to 1987 days when these data become available. The resultant costs shall be trended to [1988] the rate year by the trend factor determined pursuant to section 86-1.58 of this Subpart. For purposes of this subdivision, hospitals shall be combined into the following peer groups:

(1) The downstate residential health care facility group consisting of hospitals located in the five boroughs of New York City, and Suffolk, Nassau, Westchester and Rockland counties, and

(2) The upstate residential health care facility group consisting of all other hospitals in the state.

(e) Non-Medicare exempt unit costs.

(1) For those exempt hospitals and units which meet the requirements set forth in section 86-1.57 of this Subpart and which have submitted separately identifiable cost and statistical data for the 1981 calendar year, the non-Medicare exempt unit costs excluded from the 1987 reimbursable cost base shall be calculated as follows:

(i) The 1981 separately reported exempt unit costs shall be trended to 1985 and adjusted for changes in volume and case mix for all payors according to the provisions of this Subpart applicable in 1985.

(ii) The Medicare share of the 1985 reimbursable costs calculated pursuant to subparagraph (i) of this paragraph shall be subtracted. The Medicare costs removed shall be calculated based upon 1985 exempt unit data only, if available, or, if such data are not available, based upon the

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overall Medicare percentage used for rate setting purposes according to the provisions of section 86-1.54(c).

(iii) The remaining non-Medicare reimbursable costs shall be adjusted for changes in non-Medicare volume and non-Medicare case mix according to the provisions of this Subpart applicable in 1986 and 1987 and trended to [1988] the rate year.

(2) For those hospitals which meet the requirements set forth in section 86-1.57 of this Subpart but which have not submitted separately identifiable costs and statistical data for the 1981 calendar year, non-Medicare exempt units costs shall be calculated by multiplying a wage-adjusted exempt unit average cost per day for units providing comparable care by the facility's WEF and by an estimate of the exempt unit's expected non-Medicare days.

(f) Outlier and transfer costs.

(1) An estimate of long stay outlier costs shall be determined by multiplying the hospital-specific non-Medicare cost per day determined pursuant to subparagraph (i) of this paragraph by 60 percent, a long stay case mix factor determined pursuant to subparagraph (ii) of this paragraph and the number of long stay outlier days.

(i) The hospital-specific non-Medicare case mix neutral cost per day for outlier and transfer cost removal shall be calculated using the hospital's [1988] rate year hospital-specific operating costs determined pursuant to paragraphs (b)(1) and (2) of this section and excluding the sum of indirect GME costs and high cost outlier costs and dividing the result by the sum of non-Medicare acute patient days (excluding exempt unit and ALC days and days associated with short stay patients, transferred patients (other than those assigned to transfer

DRGs) and the outlier days only of long stay outlier patients), weighted by the corresponding case mix index factor for these acute patients days (using cost per day SIW's) and adjusted days determined pursuant to clauses (a) - (c) of this subparagraph. Adjusted days shall be developed for short stay, long stay and transfer patients to take into account their intensity and case mix, as follows:

(a) Adjusted short stay days shall be determined by multiplying the number of short stay days, the adjustment factor for short stay days (1.5) and the case mix index for short stay days, as calculated pursuant to the provisions of this subdivision.

(b) Adjusted long stay days shall be determined by multiplying the number of long stay days, the intensity factor for long stay days (0.60) and the case mix index for long stay days as calculated pursuant to the provisions of this subdivision.

(c) Adjusted transfer days shall be determined by multiplying the number of transfer days (other than those of patients assigned to transfer DRG's), the intensity factor for transfer days (1.2) and the case mix index for transfer days, as calculated pursuant to the provisions of this subdivision.

(ii) A long stay case mix factor shall be calculated by multiplying the number of non-Medicare long stay days in each DRG by the cost per day SIW for the DRG, summing the results across all DRGs, and dividing the sum by the number of non-Medicare long stay days.

(2) Short stay outlier costs shall be determined by multiplying the hospital specific non-Medicare cost per day determined pursuant to subparagraph (1)(i) of this subdivision by a short stay adjustment factor of 150%, a short stay case mix factor determined pursuant to this paragraph, and the number of non-Medicare short stay outlier days. The short stay adjustment factor reflects the relative consumption of short stay patients compared to all non-Medicare inlier cases on a statewide non-Medicare case mix adjusted average per diem basis. A short stay case mix factor shall be calculated by multiplying the number of non-Medicare short stay days in each DRG by the cost per day SIW for the DRG, summing the results across all DRGs, and dividing the sum by the number of non-Medicare short stay days.

(3) High cost outlier costs. For purposes of removing the outlier costs of high cost outliers from the reimbursable cost bases of hospitals with ancillary and routine charge schedules, the commissioner shall determine the total costs of patients' stays exceeding the greater of the hospital's average cost for the diagnosis related group to which the patient is assigned multiplied by two or the overall average cost per case of the hospital multiplied by six. The methodology used will depend on the proportion of the hospital's 1987 non-Medicare discharges for which the hospital has submitted complete bills covering the entire length of stay. These methodologies are set forth in subparagraphs (i) - (iv) of this paragraph. However, for purposes of establishing initial 1988 rates of payment for all hospitals, the proportion of hospital's cost bases subtracted for high cost outlier costs shall be the proportion calculated pursuant to the provisions of subparagraph (iii) of this paragraph.

In the case of all hospitals assigned to the major public hospital group for purposes of calculating a group average cost per discharge pursuant to section 86-1.54 (b) with the exception of hospitals with ancillary and routine charge schedules, the proportion of the cost base subtracted for high cost outliers shall be the proportion calculated for the hospital's group as defined pursuant to subparagraph (iii) of this paragraph (based on data used to calculate 1985 SIWs) and cost outlier costs so removed shall be added back in on a hospital-specific basis as part of major public hospital's specific costs as defined in section 86-1.54 (g).

The Commissioner shall recompute the proportion of hospitals' cost bases associated with the outlier portion of the high cost outlier patients' length of stay after August 1, 1988 subject to the provisions of subparagraphs (i)-(iv) of this paragraph based upon the percentage of bills for 1987 discharges submitted prior to August 1, 1988.

(i) If the hospital has submitted complete bills covering the entire length of stay for at least 90% of the hospital's 1987 discharges, then the proportion of the hospital's cost base associated with the outlier portion of high cost outlier patients' lengths of stay shall reflect the proportion calculated on the basis of those discharges for which the hospital has submitted complete bills covering the entire length of stay.

(ii) If the hospital has submitted complete bills covering the entire length of stay for less than 90% but greater than or equal to 80% of the hospital's 1987 discharges, then the proportion of

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